

TO:

FROM:

DDD Region

Dear

The Division of Developmental Disabilities (DDD) is processing an eligibility determination for \_\_\_\_\_. We cannot substantiate his/her DDD eligibility without the following information.

1. What is the DSM diagnosis for \_\_\_\_\_?

- ☐ Autistic Disorder (299.00)
- ☐ Childhood Disintegrative Disorder (299.10)
- ☐ Pervasive Developmental Disorder Not Otherwise Specified (299.80)
- ☐ Retts's Disorder (299.80)
- ☐ Asperger's Disorder (299.80)

2. Identify which of the following delays or abnormal functioning was present prior to age three:

- ☐ Social interaction
- ☐ Language as used in social interaction
- ☐ Communication, or
- ☐ Symbolic or imaginative play

- **If you checked a box in #2, please indicate how you confirmed this:**

- **If you have written evidence supporting #2, please enclose a copy when you return this letter.**

\_\_\_\_\_  
DOCTOR'S PRINTED NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DOCTOR'S SIGNATURE

\_\_\_\_\_  
TITLE

Please complete, sign, and return this information to DDD by \_\_\_\_\_. If we do not receive your reply by this date, a determination will be made based on the information available to us.

If you have questions please call:

\_\_\_\_\_ at \_\_\_\_\_

Enclosure: Consent form, if needed  
Autism Checklist, if needed